A.2.0

Application Process

General
This section contains procedures for handling requests to apply for the CMS Program. The adult requesting CMS or CMS Hardship may live alone, with a spouse, or with family members who are eligible to Medi-Cal.

When a CMS case is established using the CMS IT system, all documentation and verifications used to determine eligibility to and level of coverage within the CMS Program, including CMS forms completed by the patient and eligibility staff, must be imaged and saved into the CMS IT system. The Image Verification Checklist (CMS-107) may be used to eliminate the scanning of some forms for applicants/beneficiaries during the application process.

A.2.1

Family Resource Centers

A. **Screening**	When adults go to one of the Family resource Centers to apply for medical coverage, they must complete a Welcome Form (16-94). Information from this form helps the screener determine if the adult is potentially eligible to Medi-Cal or CMS. Adults who are not linked to Medi-Cal are given a CMS brochure. The CMS brochure gives information about the CMS Program, including the CMS eligibility appointment number.
B. **Initial** **Interview**	Adults who are ineligible members of an MFBU or who have a disability evaluation pending and have a medical need are given a CMS brochure.

A.2.2

Hospital Outstationed Services (HOS)

General

The procedures in this section apply to HOS workers only.

**A.
Application
Form/
Application
Date**

Aside from the exceptions listed below, CMS eligibility is established the date the worker receives the CMS IT System application referral or the date of admission to the hospital whichever is earlier.

Exception #1: If the CMS IT System application referral is received by the HOS worker more than 10 calendar days after the date of admission, eligibility is established the date the HOS worker received the application referral.

Exception #2: If the HOS worker receives a request for CMS to cover an Emergency Room (ER) visit occurring prior to the hospital admission, AND ONLY if the HOS referral was received within 30 days of the ER visit, the application date shall be the date of the ER visit. However, if the referral was not received within 30 days of the ER visit, or if the patient is determined ineligible for any reason for the ER visit month, then this exception does not apply and there is no CMS coverage for the ER visit. HOS workers shall refer to MPG A-2-3A for additional eligibility criteria regarding requests for coverage of an ER visit (uncertified visit) for a prior month.

**B.
Statement of
Facts/Grant of
Lien Form**

HOS workers use the Statement of Facts located on the CMS IT System plus appropriate supplemental forms to determine CMS eligibility. Refer to MPG 4-2-4 for instructions on who may complete and sign the Statement of Facts and information regarding Authorized Representatives. A copy of the signed Statement of Facts signature page shall be maintained in the case record.

When an Individual applies for CMS, the worker will screen for the CI Program first (See A-2-6 below and the CI Program Guide). If the applicant is potentially eligible for CI, the worker will explain the benefits of the CI program and ask the applicant if he/she would like to be evaluated for CI. If yes, the worker will process the CI and CMS applications concurrently, but will enroll the applicant in only the CI program if the applicant qualifies for CI.

Effective 12/01/07, as a condition of eligibility, all applicants are required to sign the CMS Lien Information form (CMS-123) and CMS Grant of Lien form (CMS-122) naming the County of San Diego as grantee to secure any and all real property of the applicant as security for repayment of all claims totaling $5,000 or more paid by the CMS Program on their behalf. The CMS Lien Information form (CMS-123) and the CMS Lien Acknowledge Statement (CMS-123A) may be included on the Image Verification Checklist (CMS-107). The CMS-122 may not be included on the CMS-107. The lien will be filed against <u>any real property that is currently owned</u> or real property that may be purchased in the future. Refer to MPG Article A, Section 5-5 for additional information regarding liens.

**C.
Face to Face
Interviews**

1. Waiving the Face-to-Face Interview

The HOS worker may waive the face-to-face interview when the applicant has been discharged before the intake interview can be scheduled. The HOS worker sends a standard appointment letter giving the applicant the option of returning to the hospital or completing the application by mail.

2. Processing Mail-in Applications

When the applicant chooses to mail in forms and verifications, the HOS worker will:

a) Review the forms for completeness and accuracy.
b) Clarify discrepancies and missing information by phone.
c) Document the phone conversation and clearly narrate the clarification in the case narrative.
d) Note the information in the County Use Section of the Statement of Facts, including an entry to "see narrative dated _____."
e) Return Statement of Facts pages when the signature is missing, or when the majority of the form is not completed, or in the event that a fraud referral has been made. Workers must have the applicant/beneficiary complete the missing items on the Statement of Facts. The worker shall:
   (1) Send a copy of the page with the missing information to the applicant/beneficiary to complete.
   (2) Send a notice of action requesting the applicant/ beneficiary provide the completed form(s) along with any necessary verification within 10 days from

the date of the notice.

(3) Continue processing the case with the information received over the phone, however, the worker must receive all completed forms, including signature and required verifications prior to the approval of CMS benefits.

D.
Rights and Responsibilities/ Lien Information /Grant of Lien/ Credit Check Authorization

Applicants must help the worker determine CMS eligibility by:

1) Completing all required forms.
2) Providing all necessary verification.
3) Reporting all pertinent facts within 10 days of their intake appointment.
4) Reading and signing the Rights and Responsibilities form (HHSA: CMS-15). Applicants who do not attend a face-to-face interview must return the signed originals to the worker for the case record.
5) Reading and signing the CMS Lien Information form (CMS-123) and the CMS Grant of Lien form (CMS-122). Applicants who refuse to provide the signed form and agreement are not eligible to CMS and their application will be denied.
6) Effective with applications taken on or after July 1, 2008, As a condition of eligibility applicants/beneficiaries must sign a Credit Check Authorization Form (CMS-99). The credit checks will be used as a verification tool for financial, property and eligibility information only, which the applicant/beneficiary provided.

E.
Case Handling

1) Case Folder

HOS is unique in that workers may be dealing with both an electronic CMS IT system case, as well as a Medi-Cal case, automated through CalWIN. Case handling is different depending on the status of the patient's Medi-Cal eligibility.

   a) CMS only FBU

     When the FBU contains only adults, the HOS worker creates an electronic case in the CMS IT system. The manual non-automated CMS case folder will be requested from Record Library (RL) for review only and

then returned to RL for storage.

b) When the applicant is an ineligible member of a Medi-Cal case, the HOS worker creates a separate CMS case electronically in the CMS IT system, as stated in item (e) below. This CMS case lists the CMS adult(s) only. However, CMS eligibility is based upon the income and property of the total MFBU, except when Sneede and Gamma rules apply. Refer to MPG Article 5, Section 13 for Sneede and Gamma rules.

c) If there is an existing non-automated case file at another eligibility site, the worker may request the case folder to retrieve previously received verifications. There should not be a new case folder created.

d) Prior to March 2007, CMS only cases were tracked using the case name only. As of March 2007, in order to prepare for the eventual storage of all CMS cases at the County Record Library, case folders shall be manually created and a case number shall be assigned. Workers shall manually create or convert new and existing case folders to a 6-digit case number.

e) As of July 1, 2008, CMS eligibility determinations are automated. Workers will enter applicant information directly into the CMS IT System, AuthMED, there is no paper case file created. The CMS IT System will assign case numbers to each applicant. The applicant will retain this case number throughout the lifetime of the CMS case.

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 4-13-3B (1), the worker prints the automated #936 from the CMS IT System, to inform CMS applicants that they have an additional 10 days to provide the verifications that were not provided during the initial 10-day period.

3) Denial – Excess Income

Income is a CMS eligibility factor. The worker inputs the applicant information directly into the CMS IT System, and the system will determine whether or not the CFBU is within the

CMS income limits and to which CMS eligibility category (CMS or CMS Hardship) the patient may be certified for. When the patient is not eligible to CMS due to excess income (more than 165% FPL up to and including 350% FPL) and is otherwise eligible, the patient may apply for a CMS Hardship Evaluation. Refer to Article A, Section 13 for additional information. The worker shall not deny the case, but will continue to evaluate whether the patient is eligible for a CMS Hardship evaluation. The worker shall advise the patient of the repayment agreement and the 10 day deadline in which to provide any pending verifications.

When denying the application for excess income (more than 350% FPL), it is imperative that the correct CFBU size as well as both the total gross and the net countable income used in the determination are reflected. NOA HHSA: CMS-39D is provided to the CMS applicant, indicating reason for denial and the budget used in the determination.

4) CMS Approved – No Medi-Cal Disability Evaluation (DDSD Pending

Workers enter the applicant information directly into the CMS IT System to certify CMS applications. The Notice of Action CMS-39A is used to inform the applicant of the approval and the eligibility category to which they have been approved.

5) CMS Approved – Medi-Cal Disability Evaluation (DDSD) Pending

The worker opens an automated Medi-Cal case on CalWIN and places it in a pending status. The worker must also evaluate for retroactive Medi-Cal when the applicant/ beneficiary has had CMS coverage in the retroactive period. The HOS worker shall assist applicants, as needed, with the Medi-Cal application process including helping them complete the Statement of Facts and DDSD packet (see Medi-Cal Linkage in Article A, Section 2, Item 5 for more instructions). **(The HOS worker CANNOT approve CMS until the Medi-Cal application and DDSD packet are received fully completed and all eligibility and verification requirements for both Medi-Cal and CMS have been met.)** In addition, CMS should not be certified if there is a pending fraud investigation on the Medi-Cal application. The date the DDSD packet was sent must be recorded on the CalWIN Disability screen within 30 days from the date of application.

Reminder: Per MPG 5-4.2, DDSD's <u>must</u> be submitted within 10 days of receipt of the Statement of Facts.

Note: If CalWIN Disability Screen input is not completed within 30 days from the date of application, all CalWIN entries will fail. The worker records the CMS certification period and the date the DDSD packet was sent in the case comments of the CMS and Medi-Cal case. Example: CMS 5/05-10/05, MC P (xx/xx application date) DDSD sent 6/12/05. This entry alerts the DDSD Recovery Specialist that there is potential reimbursement from Medi-Cal to CMS. The HOS worker then sends the Medi-Cal case to the DDSD workers at the Family Resource Centers (FRC). IDX screen prints reflecting CMS eligibility and IDX comments must be in the case file as referenced in MPG Article 4, Section 2.7(C). Upon approval or denial of Medi-Cal, the DDSD FRC worker sends form 14-10 HHSA to the ASO at O-557B. The CMS case is sent to HQ for filing in the Record Library.

**F.
Notification**

Workers must verify through the CMS IT System that the appropriate Notices of Action were sent to applicants, including the Notice of Privacy Practices and the CMS Medical/Dental Form (HHSA-CMS-127) when certifying or recertifying CMS eligibility.

The CMS IT System will upload to the ASO at the end of the business day notifying the IDX System when CMS eligibility is approved or denied. Hospitals are able to view the status of an applicant's eligibility using the CMS IT Systems Provider Online Verification (POV) site.

**G.
Clinic
Assignment**

1) Upon approval, the worker asks the beneficiary to pick one of the primary care clinics (PCC) that contract with CMS as a medical home. Worker enters the PCC site in the CMS IT System which will be transferred to the CMS card and mailed to the beneficiary. If the patient is not able or available to select a PCC site, the worker will designate the PCC site based on the following factors:

- PCC site closest to beneficiary's address;
- PCC site previously designated in IDX, or
- Select the site based on information known to the worker as to where follow-up care would be given.

2) Native Americans

When the worker is aware that a CMS beneficiary is a Native American, the worker enters the information into the CMS IT System the appropriate form the HHSA:CMS-120, "Health Services Information for Native Americans" will populate which informs Native Americans that they may choose to receive their primary health care through the CMS Primary Care Clinic they selected as part of the CMS enrollment process and/or a participating Indian Health Clinic. The worker must narrate that the form was given.

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**H.
CMS Card**

Upon approval, the CMS IT System will mail the CMS card along with the Approval Notice of Action (NOA) within 3 business days. The CMS card will not be automatically mailed to the homeless applicants. Once an approval action is taken an electronic version of the NOA and CMS card will be available on the CMS IT System. The worker will be able to print the NOA and CMS card for the applicant upon request. The CMS identification card is attached to the bottom of the NOA with a perforated seam. Certification Period will no longer be printed on the card, but will be stated on the NOA. Printed on the CMS identification card is the member number and the PCC site chosen.

**I.
Patient
Handbook**

Upon approval of CMS, the worker informs the beneficiary that the CMS Patient Handbook will be mailed within 3 business days along with the Approval NOA and CMS card. The CMS Patient Handbook will not be automatically mailed to the homeless beneficiary. The worker gives a CMS Patient Handbook to the homeless beneficiary. The handbook provides information on how to access care through the CMS Program. It lists the CMS scope of services, contracted clinics, hospital and pharmacies as well as the information regarding required Share of Cost. Information is also provided regarding how to resolve problems, file complaints and file appeals.

**J.
Share of Cost**

Workers shall give the applicant the CMS-39A NOA and review the Share of Cost (SOC) with patient explaining the payment process.

K.

Beneficiaries shall sign the form acknowledging that they have

Coverage Information	reviewed the information and they understand the limitations of CMS coverage and their responsibilities for Share of Cost (SOC) payments when certified for CMS with a SOC. A copy of the signed form shall be maintained in the case record.
L. Lien Information	Applicants/beneficiaries shall complete the CMS-122 and sign the CMS-123 acknowledging that they have reviewed the information, and that they understand and agree to the requirements for repayment of any and all claims totaling $5,000 or more which are paid for on their behalf by the CMS Program (refer to Article A-5-5 for more information). A copy of the signed forms shall be maintained in the case record. The Grant of Lien form (CMS-122) must be signed and witnessed at every application and reapplication. Staff may waive the lien requirement for recertification after they verify the Grant of Lien form (CMS-122) obtained during the application/reapplication process was signed and witnessed by either a Deputy County Clerk or a Notary Public. If the lien form on file was not witnessed by either a Deputy County Clerk or a Notary Public, the worker shall obtain new lien forms.

A.2.3

Primary Care Clinics and Public Health Centers

General	The procedures in this section apply only to workers at Primary Care Clinics (PCC) and Public Health Centers.

A. Statement of Facts/Grant of Lien form

The date the applicant's information is entered into the CMS IT system establishes the date of application. The worker will print the MC-210 on the date of the intake interview and have the applicant sign and date the form, which is then scanned into the IT System to verify the application date. The CMS IT System gathers information to determine CMS eligibility. Refer to MPG 4-2-4 for instructions on who may complete and sign the Statement of Facts and information regarding Authorized Representatives.

When an Individual applies for CMS, the worker will screen for the CI Program first (See A-2-6 below and the CI Program Guide). If the applicant is potentially eligible for CI, the worker will explain the benefits of the CI program and ask the applicant if he/she would like to be evaluated for CI. If yes, the worker will process the CI and CMS applications concurrently, but will enroll the applicant in only the CI program if the applicant qualifies for CI.

All applicants must also complete lien forms. Refer to Article A-2-2B.

Exception: Applicants requesting coverage for an uncertified date of service prior to the date of the intake interview may establish the date of the uncertified visit as their application date and eligibility will be effective the first on the month of the date of the uncertified visit if all of the following conditions are met:

1) The applicant was not CMS certified at the time they received medical treatment as (a) an Outpatient at an emergency room (ER) or a primary care clinic/public health center, or (b) as an Inpatient admitted to the hospital through the ER and released in less than 24 hours. The applicant is now requesting CMS coverage for that uncertified date of service.

2) The applicant contacts the Administrative Services Organization (ASO) within 30 calendar days of the date of the uncertified visit to schedule the intake interview.

3) The applicant provides verification of the date of the uncertified visit. The date of the uncertified visit, once verified, then becomes the date of application.

4) The applicant provides all of the information and required verifications needed to determine eligibility for the month of the uncertified visit.

5) The applicant meets all other eligibility requirements for the month of the uncertified visit.

6) The applicant may request coverage for a maximum of two uncertified visits per year.

7) Patients have 10 business days from the date of the missed appointment to call ASO to reschedule. Only one reschedule will be allowed for patients requesting coverage of a past month's ER visit. The application date for a patient with more than one reschedule shall be the date of the intake appointment and not earlier.

**B.
Face-to-Face
Interview**

1) Waiving the Interview

Workers must waive the face-to-face interview when applicants or beneficiaries are living in a skilled nursing facility, intermediate care facility or board and care. Workers must also waive the face-to-face interview when applicants or beneficiaries are housebound because of illness or injury. However, these applicants and beneficiaries may request a face-to-face interview.

The worker may request to waive the face-to-face interview for other reasons based on the individual needs of the applicant or beneficiary. This will be done on a case-by-case basis and with supervisor approval. The reason for waiving the interview must be documented in the case comment in the CMS IT System.

Face-to-face interviews are also waived for hostile or uncooperative applicants/ beneficiaries.

2) Processing Mail In Applications

Workers process mail-in applications in the same manner as HOS. See Article A-2-1E(2).

C. **Rights and Responsibilities /Lien Information /Grant of Lien/ Credit Check Authorization**	Applicant Rights and Responsibilities, Lien Information, Grant of Lien and Credit Check Authorizations are the same as HOS. See Article A-2-2D.
D. **Case Handling**	1) Case Folder Workers create an electronic case in the same manner as HOS. Refer to Article A-2-2E(1a) and A-2-2E(1c). 2) Denial/Failure to Provide Requirements CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 4-13-3B(1), the worker prints the CMS automated letter from the CMS IT System, Reminder Request for Verifications. This letter must be sent as a reminder notice to CMS applicants to inform them that they have an additional 10 days to provide verifications that were not provided during the initial 10-day period. 3) Denial – Excess Income Workers are to follow the same process as HOS. Refer to MPG Article A, Section 2-2-E(3). 4) Approved – Medi-Cal Disability Evaluation (DDSD) Pending Workers at Primary Care Clinics and Public Health Centers may certify CMS eligibility for up to three months after directing an applicant/beneficiary to apply for Medi-Cal. The worker will print the MC-210 from the CMS IT System and give it to the applicant. The worker must specify on the MC-210 the beginning month for the Medi-Cal DDSD application and retroactive months as needed. Retroactive Medi-Cal is needed when the applicant/beneficiary has had CMS coverage in the retroactive period. Workers shall assist those who need help completing the Statement of Facts (MC 210) and Supplemental

Statement of Facts (MC 223), etc. The worker must inform the applicant verbally and on the Notice of Action that CMS will not be recertified until they fully complete the Medi-Cal application process. After the three-month period, CMS cannot be approved until the worker verifies the applicant/beneficiary has fully complied in completing the Medi-Cal application process; met all Medi-Cal eligibility and verification requirements; and the Medi-Cal application is pending on CalWIN with the date the DDSD packet was sent. (See Medi-Cal Linkage in Article A Section 2 Item 5 for more instructions.)

E. Notification

Workers must verify through the CMS IT System that the appropriate Notices of Action were sent to applicants, including the Notice of Privacy Practices and the CMS Medical/Dental Form (HHSA-CMS-127) when certifying or recertifying CMS eligibility.

The CMS IT System will upload to the ASO at the end of the business day to notify the IDX System when CMS eligibility is approved or denied. Hospitals/clinics are able to view the status of an applicant's eligibility using the CMS IT Systems Provider Online Verification (POV) site.

F. Clinic Assignment

1) Choosing a Clinic is the same for all CMS beneficiaries (see Article A.2.2.G.1)).

2) Native Americans (see Article A.2.2.G.2)).

3) Changing Clinics

When beneficiaries want to change their primary care clinic (PCC) because they have moved or prefer a clinic closer to their home or work, they can ask the worker to change the clinic designation in IDX. The worker will input the new PCC site into CMS IT System which will up load to IDX the next business day. No label will be mailed to the beneficiary, as the providers have access to the eligibility and PCC site via the POV site. When beneficiaries are dissatisfied with their primary care clinic, they must call the CMS Patient Information Line (858) 492-4444. The ASO will evaluate what is causing the dissatisfaction and will inform the worker to change the clinic, if appropriate.

4) Discharged from a Clinic

When a beneficiary has been discharged from a clinic because of problems or conflicts with the clinic staff that cannot be resolved, the worker will direct the beneficiary to select another clinic. The worker will write in the comment section of the CMS IT System "discharged from (clinic name and date)." This information will become an alert in IDX that this beneficiary cannot select this particular clinic as a medical home. The beneficiary will receive written notification from the clinic stating that he or she can no longer get services there.

**G.
CMS Card**

Workers issue cards in the same way as the HOS workers. See Article A-2-2H.

**H.
Patient
Handbook**

Patient Handbook is issued in the same way as the HOS workers. See Article A-2-2I.

**I.
Share of Cost**

See article A-2-2J.

**J.
Coverage
Information**

Workers shall review the Coverage Information form HHSA: CMS-23 in the same way as HOS workers. See Article A-2-2K.

**K.
Lien
Information**

Workers shall review and sign the completed CMS Lien Information form (CMS-123) and CMS Grant of Lien form (CMS-122) in the same way as HOS workers. See Article A-2-2L.

A.2.4

Applicant in Facility Outside of San Diego County

**A.
County
Resident**

A key person or county representative may initiate a CMS application for a County resident hospitalized outside of the County. The key person or county representative calls the CMS Patient/Provider Relations Manager at (858) 492-4422. The Manager will coordinate the completion of the application with HCA.

**B.
Not a County
Resident**

CMS does not coordinate the transfer of care or provide coverage for anyone who was not a County resident at the time of admission to the out-of-county facility, even if the individual intends to live in San Diego County after discharge from the facility.

A.2.5

Potential Linkage to Medi-Cal

A. Potential Linkage to Medi-Cal Disability	CMS applicants and beneficiaries with a disabling condition that may potentially link them to Medi-Cal must apply for and if eligible, accept Medi-Cal coverage. If they refuse to apply for or accept full scope Medi-Cal, they are not eligible to CMS.

1) CMS requires some patients to apply for disability linked Medi-Cal through Disability Determination Services Division (DDSD) as a condition for eligibility for CMS and generally follows Medi-Cal regulations regarding applying for unconditionally available income. Medi-Cal does not consider SSI unconditionally available income because it is viewed as Public Assistance. A CMS applicant who has been identified as potentially eligible to Medi-Cal or SSI may be referred to the Legal Aid SSI Advocate for assistance in applying for or reapplying for SSI benefits or assisting with the process of filing an SSDI/SSI appeal. Worker will either mail or fax form HHSA: CMS2 to the Legal Aid SSI Advocate and notes in the case comment section of the CMS IT system, "SSI Advocacy Services referred." (See Article A, Section 7, Item 3C for more information.)

2) A CMS applicant/beneficiary with a pending SSI or SSA Disability application or appeal decision should have applied for Medi-Cal at the time they applied for SSI/SSA. If they did not apply, in order to protect the Medi-Cal filing date, the CMS worker must refer or process the Medi-Cal application as instructed in MPG Article A, Section 2, Item 3.D.4. Medi-Cal applicants appealing an SSI/SSA denial issued within the last 12 months for not having a disabling condition may be denied Medi-Cal on the basis of no disability in CalWIN. This denial action protects the Medi-Cal filing date so that if the final appeal decision is favorable to the CMS beneficiary, CMS Recovery staff will initiate a corrective action memo to rescind the Medi-Cal denial and receive reimbursement from Medi-Cal.

3) If the CMS applicant/beneficiary is denied disability linked Medi-Cal (DDSD) because he or she is not linked and returns to apply for CMS within ninety (90) days of the Medi-Cal denial, the worker must review the denial reason. If the denial is correct and is not due to no show, failure to provide

or failure to cooperate, the worker may certify for the standard period, if otherwise eligible, and must document the Medi-Cal denial reason in the case record comments. If the denial reason is questionable, (e.g. SSI denied for reasons other than no disability; 250% Working Disabled Program not evaluated for working individual, etc.), the worker must refer the applicant/beneficiary to appeal and may certify for up to three (3) months. If the ninety (90) day appeal timeframe has expired, the worker must re-refer the applicant/beneficiary to apply for Medi-Cal and may certify for up to three (3) months. This allows the applicant enough time to appeal the denial while getting the necessary medical treatment. The worker must select the appropriate status code from the Medi-Cal status box in AuthMed and state the reason for the short certification in the case record comments and on the NOA that approves CMS.

4) If a new CMS applicant was denied disability linked Medi-Cal (DDSD) because he or she is not linked and continues to declare a disabling condition, the CMS worker will evaluate if the denial is within the Medi-Cal ninety (90) day appeal timeframe. If it is within the appeal timeframe, the worker must refer the applicant to appeal and may certify for up to three (3) months. If the appeal timeframe has expired, the worker must re-refer the applicant to apply for Medi-Cal and may certify for up to three (3) months. The worker must select the appropriate status code from the Medi-Cal status box in AuthMed and state the reason for the short certification in the case record comments and on the NOA that approves CMS.

5) If the Medi-Cal application is denied for a reason unrelated to disability, such as no show, failure to provide, or failure to cooperate, they are not eligible for CMS until they comply.

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**B.
Medi-Cal
Disability
Linkage is
Established**

CMS beneficiaries determined to be disabled by State or Federal DDSD are ineligible to CMS. Upon receipt of the DDSD decision, CMS enters the disability information into IDX and HCPA CMS Recovery staff sends informing letter (HHSA: CMS 34) telling beneficiaries to complete the Medi-Cal application process. CMS eligibility continues until the certification period expires or until eligibility to full scope Medi-Cal begins, whichever occurs first. CMS beneficiaries who have

applied for Medi-Cal have the responsibility to complete the entire Medi-Cal application process. If they have been determined disabled, but fail to finish the Medi-Cal eligibility determination process, they cannot remain on, or return to CMS.

**C.
Deceased Person**

Because CMS is the program of last resort, it will not consider applications made on the behalf of a deceased person. CMS denies all provider claims for services given to a CMS beneficiary who dies while in the hospital. In this situation, the beneficiary is linked to Medi-Cal because Medi-Cal defines disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death."

**D.
Cash Assistance Program for Immigrants (CAPI) Applicants**

CAPI is a cash program for certain immigrants who are ineligible to SSI/SSP solely due to their immigration status. All CAPI applications and re-determinations are processed in the Mission Valley Family Resource Center. A CMS applicant who has a pending CAPI application **must also** apply for Medi-Cal and may be granted CMS pending the DDSD decision. The DDSD process for CAPI is the same as Medi-Cal; however a separate Medi-Cal application has to be requested by the applicant. A CMS applicant who has an active CAPI case is linked to Medi-Cal and is not eligible to CMS.

A.2.6

Linkage to Coverage Initiative (CI)

**A.
Linkage**

CI is a federally funded program for individuals with chronic conditions such as hypertension, and diabetes (refer to the CI Program Guide for a complete listing of eligible conditions). When an applicant applies for CMS, the worker will screen for the CI Program first (See CI Program Guide). If an applicant is potentially eligible for CI, the worker shall explain the benefits of the CI program and ask the applicant if he/she would like to be evaluated for CI. If yes, the worker will process the CI and the CMS applications concurrently, but will enroll the applicant in only CI program if the applicant qualifies for CI. If there are pending verifications for CI, the worker is to send/give the pending verifications checklist to the applicant informing them of the 10 day requirement to provide verifications needed for both CI and CMS. The worker will refer the applicant to the Certified Applicant Assistor (CAA) for assistance in getting verifications needed for CI.

The 10/10 process will apply for all pending verifications. If after the first 10 days the applicant has provided needed CMS verifications but not CI verifications, send a second 10-day notice asking for the remaining CI verifications.   After the second 10-day period:

- Grant CI if the applicant provided the CI verifications , or
- Grant CMS if the applicant did not provide CI verifications but did provide the needed CMS verifications, or
- Deny both CI and CMS if the applicant did not provide the needed verifications for either program and does not have good cause.

**B.
Coverage
Initiative (CI)
Open
Enrollment**

The CI program is dependent on funding and enrollment limits. Enrollment will occur only during open enrollment periods. Open enrollment periods are defined via CI Special Notices. CMS eligibility workers will screen, evaluate and enroll individuals into the CI program only during the open enrollment period.

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A.2.7

Notice of Privacy Practices

General

Workers shall give the 'Notices of Privacy Practices" to all individuals are certified or recertified for CMS. This is a federal requirement under the Health Insurance Portability and Accountability Act (HIPAA). The worker must note on the case comments the date the notice was mailed/given.

A.2.8

CMS Medical/Dental Need Form (HHSA: CMS-127)

**A.
Medical/Dental
Need Form at
Certification**

At certification, the CMS it System will mail the medical need form along with the approval NOA and CMS card. The worker will advise the patient that if they have an ongoing medical need and require CMS coverage past the certification period or within six (6) months of their CMS certification expiring, the medical need form must be completed by their physician or physician's authorized designee and mailed or faxed to the CMS Administrative Services Organization (ASO) prior to scheduling their next eligibility appointment. The patient will not be given an eligibility appointment if the completed form is not received. The worker shall narrate this explanation in the IT System case record. If a CMS patient call more than six (6) months after their CMS certification has expired a CMS-127 is not needed for an eligibility appointment.

EXCEPTION:
A CMS-127 is **not** needed when:
1) AmeriChoice has an approved Treatment Authorization Request (TAR) waiting to be used. An approved TAR is verification of a medical need.
2) A CMS inpatient (as identified in the Hospital Outstationed Services (HOS) Policy and Procedures manual) has been hospitalized and referred to HOS. The hospital admission is verification of a medical need.
3) Beneficiaries identified by AmeriChoice as having a chronic medical condition by the "CHRONIC" indicator on IDX Eligibility Enrollment Summary Screen.
4) Share of Cost has been met in the last month of certification.
5) A CMS beneficiary has been treated in the emergency room and calls the CMS Eligibility Appointment (ASO) Line within 30 days of the emergency room visit to schedule an intake interview. The emergency room visit is verification of a medical need.

A CMS-127 **is** needed when:
1) Requesting a recertification appointment
2) Requesting a reapplication appointment within 6 months of their previous CMS certification expiring.

Patient can mail or fax the CMS Medical/Dental Need Form

(HHSA:CMS-127) to:
CMS Program Customer Service Supervisor
PO Box 939016, San Diego, CA 92193
FAX Number: (858) 495-1399

B.
Medical Need
Form Term Date

If a physician states on the medical need form that patient's medical treatment is expected to last for more than a year or for an "indefinite" period of time, the medical need form is valid for a period of one (1) month past the certification expiration date.

A.2.9

Credit Check Authorization and Reimbursement Agreement

**A.
Credit Check
Authorization
(CMS-99)**

All CMS applicants/beneficiaries will be required to sign a Credit Authorization Form as a condition of eligibility. CMS does not consider an applicants credit history as a basis for eligibility, but will use the credit check as a verification tool for financial, property and eligibility information which the applicant/ beneficiary provided.

**B.
Reimbursement
Agreement
(CMS-106)**

Applicants/beneficiaries whose income is above 165% of the FPL up to and including 350% of the FPL will be required to sign a reimbursement agreement. The reimbursement agreement is for the CMS applicant to reimburse San Diego County via Revenue & Recovery, for all services paid for by CMS. Pursuant to County Administrative Code section 238, HHSA will refer CMS cases to the Office of Revenue and Recovery to pursue appropriate collection activities and proceedings to recover CMS costs.

**C.
Informational
Notice
(CMS-109)**

The County's Legal Rights and Limitations on Repayment

The Informational Notice must be given to every individual receiving a Reimbursement Agreement. It informs the individual of the County's legal rights and limitations to enforce a repayment agreement.

The Informational Notice (CMS-109) will be place in all Mail-In and Retro packets and mailed to individuals.

A.2.10

Image Verification Checklist

**A.
Image
Verification
Checklist
(CMS-107)**

The Image Verification Checklist will eliminate the scanning of specific forms for applicants/beneficiaries. Workers will scan limited forms into the CMS IT System when using the Image Verification Checklist. The checklist must list the correct effective/revision date for each form given.

APPENDIX 2A

CMS Eligibility Denial Codes

A. DENIAL CHART

01	You have excess resources
02	You have excess income
03	Not a county resident
04	Not a citizen/eligible alien
05	Failure to provide/cooperate
06	Medi-Cal Linkage
08	Lien forms not complete
26	Other
27	Application withdrawn